NON-CORE ISSUES

Facility	License #	Physical Address	Phone Number
Truewood by Merrill, Boise	RC-1024	2600 North Milwaukee	208-373-1234
Administrator	City	Zip Code	Survey Date
Jody Stephen	Boise	83704	05/05/2023
Survey Team Leader	Survey Type		Response Due
Oldfield, Michael	Health Care Licensure and Follow-Up		06/04/2023

Item #	Rule (16.03.22)	Description
1	.009.01. Criminal History and Background Check.	One of ten employees, whose personnel records were reviewed, did not have a Department Criminal History and Background Check. The administrator confirmed the Department Criminal History and Background Check was not completed. ***Previously cited on 8/19/16 and 3/4/21.***
2	.009.06.a. Use of Previous Criminal History and Background Check.	The facility used a previous Criminal History and Background check for one employee who did not have a completed check with the previous three years of their hire date. The employee's hire date was 10/16/22, but the Department Criminal History and Background Check was completed on 10/06/2011.
3	.009.06.c. Use of Previous Criminal History and Background Check.	Two of ten employees, whose personnel records were reviewed and required an Idaho State Police background check, did not have an Idaho State Police background check completed. Upon interview with the Resident Care Director, it was confirmed the Idaho State Police background checks were not completed. ***Previously cited on 11/10/21 and 3/4/21.***
4	.215.08.b. Investigation within Thirty Days.	The administrator did not conduct an investigation within 30 days when Resident #9 fell on 4/5/23, 4/8/23, and 4/29/23. Nor when Resident #1 left the facility on 3/18/23 and was

		trying to hitchhike at Winco and was reported to almost get hit by a car and on 11/18/22 when Resident #1 had been "drinking excessively" and called other female residents "sweetie and beautiful" which bothered other residents. The administrator confirmed the investigations had not been completed. ***Previously cited 7/2/22***
5	.215.08.f. Notification to Licensing Agency within One Business Day.	The facility did not notify Licensing and Certification (L&C) within one business day when Resident #10 fell on 4/3/23 and required assessment and treatment by bedside X-ray and when Resident #8 had a fall and required an assessment at the hospital. The administrator confirmed they did not report the incidents to Licensing and Certification.
6	.300.02. Licensed Nurse.	Change of condition assessments were not consistently completed. For example, Resident #5 had falls on 10/4/22, 11/8/22, and 3/10/23 and did not have change of condition assessments. Resident #2 was admitted to hospice in April 2023 and did not have an assessment completed for their change of condition. ***Previously cited 11/10/21 and 3/4/21***
7	.305.06.a. Self-Administered Medication.	The facility nurse did not assess Resident #2 to ensure they could continue to safely self-administer medication after they started on hospice in April 2023, which included the addition of liquid oral morphine and lorazepam were to be administered by a route not previously assessed by the facility nurse. Also, Resident #2 stated, on 5/2/23, their medications were not audited by the facility nurse and indicated they were filling their medisets with a discontinued medication, glipizide, and medications without current orders, bumetanide and pregabalin.
8	.310.01.c. Medication Distribution.	The facility's medication refrigerator temperatures, which contained insulin, were not monitored and documented daily. The temperatures were only logged 10 days out of 31 in March 2023 and 14 days out of 30 days for April 2022. Staff stated the temperatures had not been monitored and documented

		consistently.
9	.310.04.e. Psychotropic or Behavior Modifying Medication.	Resident #3 was taking mirtazapine, risperidone, and trazodone, Resident #5 was taking sertraline, Resident #6 was taking fluoxetine and Resident #8 was taking citalopram for longer than six months and did not have completed six month psychotropic medication reviews. The former facility nurse stated the medication reviews were sent out to the doctor but did not get completed.
10	.320.01. Use of NSA.	Residents' Negotiated Service Agreements did not clearly reflect the residents' needs nor describe the services to be provided. For example: Resident #5's NSA documented they only needed standby assist for showers when they received full assist with showers from hospice. Resident #13 and #14's NSA did not list instructions for staff on how to assist them with their relationships. Resident #13's NSA did not include instructions for staff on how to respond when they yelled at other residents and their roommate. ***Previously cited 11/10/21***
11	.320.03. Signature, Date, and Approval of Agreement.	NSAs were not signed and dated by assisted living Residents #1, #2, #5, #6 nor by memory care Residents #8, #9, #10, #11, #12, #13, and #14's legal representative, Power of Attorney, or conservators. The administrator was unable to provide documentation the NSAs were signed and dated.
12	.330.04.c.vii. Resident Care Records.	The former facility nurse stated she had assessed residents for a pre-admittance assessment but did not retain these assessments to include in the residents' records for Residents #1, #3, #6, #8, #10, #11, #12 and #14.
13	.330.11.b. Dietary Records.	The facility did not document any menu substitutions. Substitutions were observed for lunch on 5/3/22. The dietary manager confirmed substitutions were not documented.
14	.330.14. As Worked Schedules.	The facility's assisted living as-worked schedule did not include the administrator, facility nurse, maintenance, and kitchen staff nor did it include last names or the exact times staff were at the facility. The memory care as-worked schedule also was

		not completed. The administrator confirmed the as-worked schedules did not include all staff, and the memory care as-worked scheduled was not maintained. The facility was provided technical assistance on as-worked schedules on a previous survey on 3/4/21.
15	.600.04.b. Sufficient Personnel.	Three of eight sampled staff did not have current certification and worked with no other certified staff during night shifts in the assisted living unit of the facility.
16	.625.02. Content for Training.	Four of ten employees' charts documented their sixteen hours of orientation training was not completed within thirty days of hire. The administrator was unable to provide documentation the training was provided within 30 days of their hire dates.